Kansas Medical Assistance Programs

HEALTHCONNECT Kansas

From the office of the Fiscal Agent

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

P.O. Box 3571, Topeka KS 66601-3571
Prior Authorization: 1-800-285-4978 or 785-274-5499
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

Weight Loss Renewal Request Form

Orlistat (Xenical ®) and Sibutramine (Meridia ®)

Consumer Name: _____
Consumer Medicaid ID #: _____ **Date Of Birth:** ____/____/_____

Name of medication requested and instructions:

_____

The following are **required** measurements and must be no more than 14 days old:

DATE	WEIGHT (lbs)	HEIGHT (in.)	BMI	WAIST CIRCUMFERENCE (in.)
(Initial)				

Indicate current % reduction in body weight from weight supplied on initial form: _____
(There must be at least a 5% reduction from baseline after initial 3 months of therapy OR if this is not the first renewal request, the patient must not regain weight to within 5% of his/her initial weight supplied for prior authorization renewal.)

Kansas Medicaid would appreciate your assistance in measuring the impact of weight loss medications on existing co-morbidities. The following information is not required for prior authorization but is requested if available. Thank you.

DATE	BP	TOTAL CHOLESTEROL	HDL	LDL	HgbA1C
(Initial)					

Physician's Printed Name: _____ **Provider Medicaid ID #:** _____
Signature of Physician or Designee: _____ **Date:** ____/____/_____
Phone number: (____)_____ **Fax number:** (____)_____

Pharmacy Name: _____ **Provider Medicaid ID#:** _____
NDC Requesting: _____
Phone number: (____)_____ **Fax number:** (____)_____

Completed form should be faxed to 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.
If a case has been started and the information requested is not received within 15 working days, the case will be denied.